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HEALTH SERVICES AND POLICY RESEARCH

Strategic Initiatives

Policy Considerations Regarding Activity-based Funding for Hospital Care

Victoria, BC
March 15th 2011

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Strategic Initiatives

- **Partners:**
  - B.C. Ministry of Health Services
  - Canadian Institutes for Health Information (CIHR)
  - Canadian Health Services Research Foundation (CHSRF)

Strategic Initiatives

- **'Big picture issues' that have been used to drive health system reform and ABF**
  - Stimulating productivity and efficiency
  - Reducing lengths of stay
  - Reducing hospital waiting lists
  - Increasing competition between hospitals to improve quality
  - Encouraging monitoring and benchmarking
  - Reducing excess capacity, increasing transparency in hospital funding
  - Facilitating patient choice
  - Harmonizing payment mechanisms between public and private providers

Strategic Initiatives

- **Hospitals now account for over $50 billion in expenditures per year**

- **What isn't working with current system?**
  - Perceived inefficiencies
  - Wait times
  - Unexplained variation in utilization/cost
  - Transparency
  - 'Bending the cost curve'

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- **Activity-based funding is 'rushing in' across Canada**
  - BC, AB, ON; incremental funding in SK, NL
  - CMA, BCMA, OMA, OHA, Kirby Commission (v.6)
- **Survey:**

  What are the provinces big-picture issues?

  - Foster transparency in hospital funding
  - Increase value for money for hospital spending
  - Specific quality outcomes
  - Improve timeliness of access

Strategic Initiatives

- **What is attractive about activity-based funding?**
  - Using funding as a ‘lever’ to increase technical efficiency
    - Economic incentives
    - Political incentives
  - Many problems are known:
    - No incentive to coordinate care, fragmented care
    - Over-provide profitable services
    - Upcoding ….
  - More than 3 decades of research and application

Strategic Initiatives

- **Activity-based funding, the evidence:**
  - Tends to shorten lengths of stay
  - Tends to increase the volume of hospitalizations
  - Tends to increase spending
  - Little evidence of effect on hospital quality
- Mixed effects:
  - Efficiency
- Other potential impacts:
  - Geographic access
  - Equity of access

Strategic Initiatives

- **No evidence:**
  - Improves evidence-based care
  - Improves effectiveness or appropriateness
  - Impact on other sectors
  - Provider engagement

  ….either does global budgeting

Strategic Initiatives

- **Survey:**

  What do the provinces think about ABF?

  - Health human resource implications
  - Waiting times
  - Quality
  - Access
    - Geographic access
    - Equity of access
  - Patient satisfaction
  - Hospital financial performance

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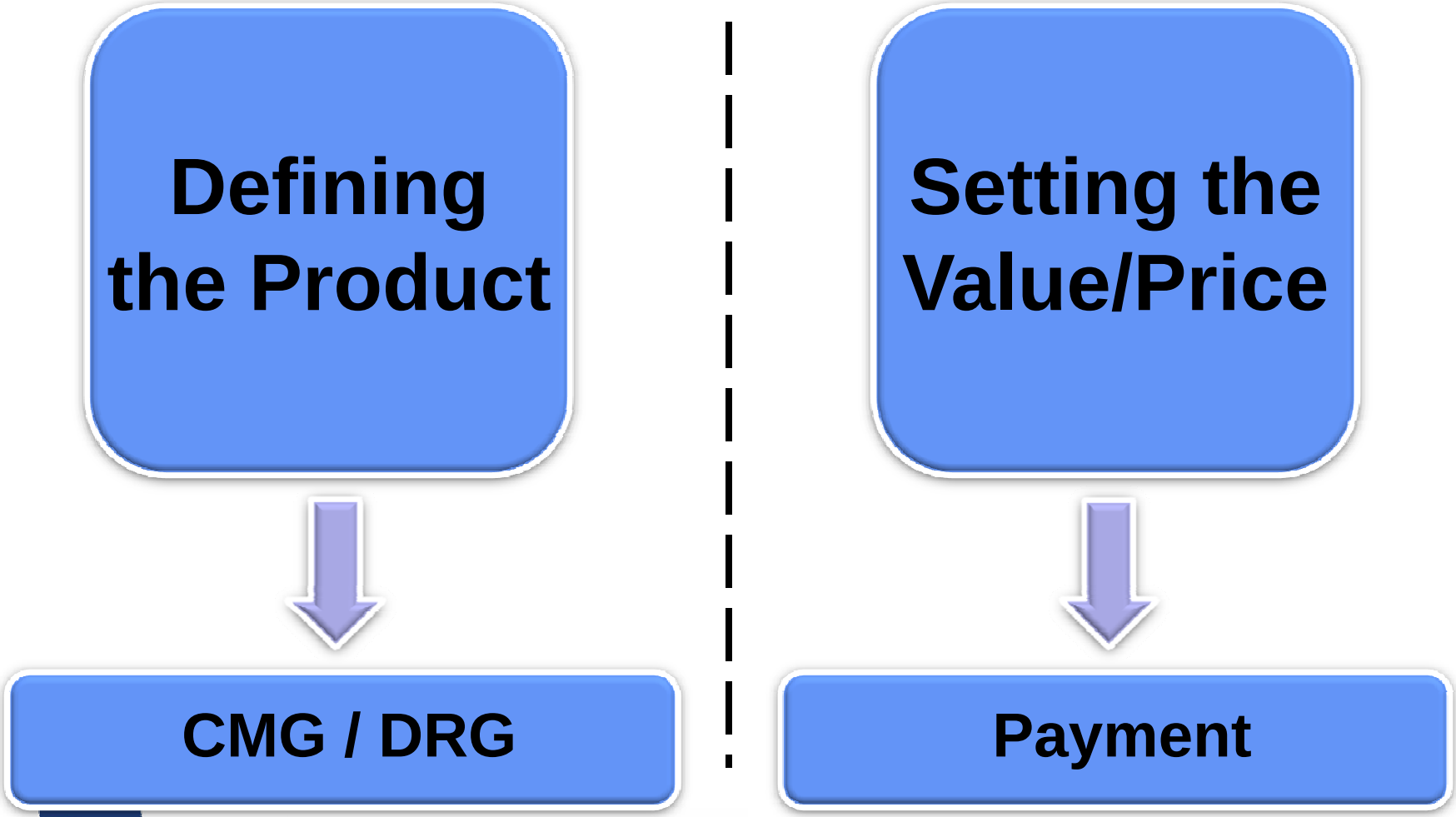
How does one get to activity-based funding?



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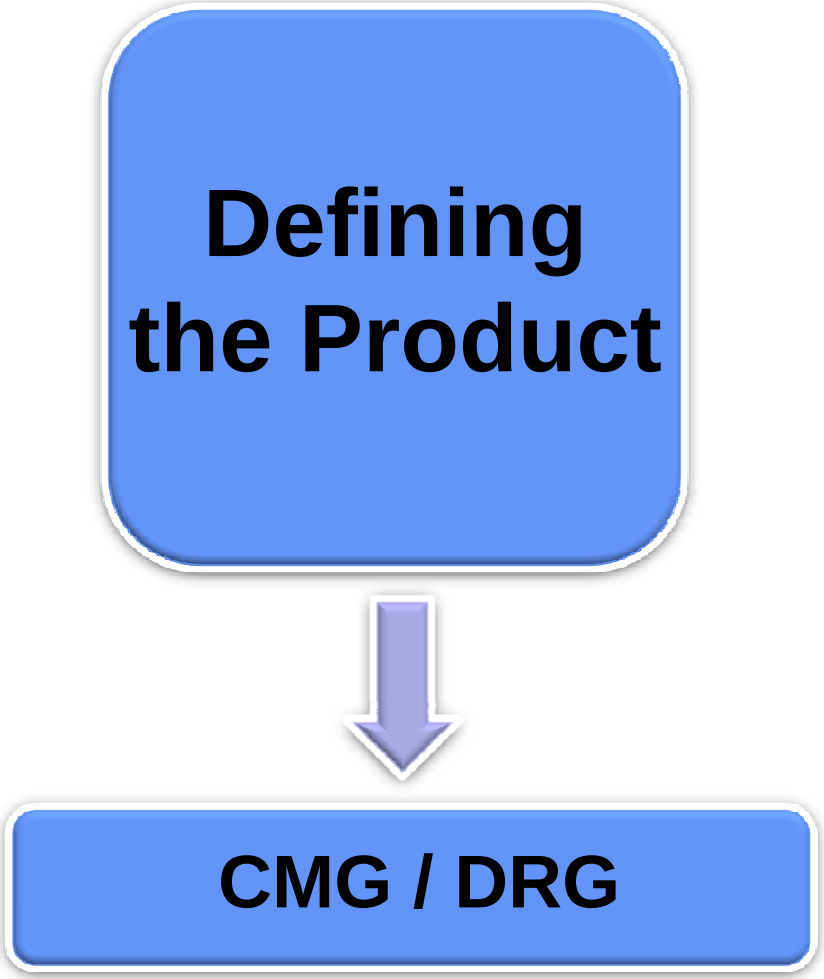
- **Generally, the payer defines the product groups it is willing to pay for**
  - **Medicare (DRG)**
  - **Department of Health, UK (HRG)**
  - **Department of Health and Ageing, Australia (AR-DRG)**



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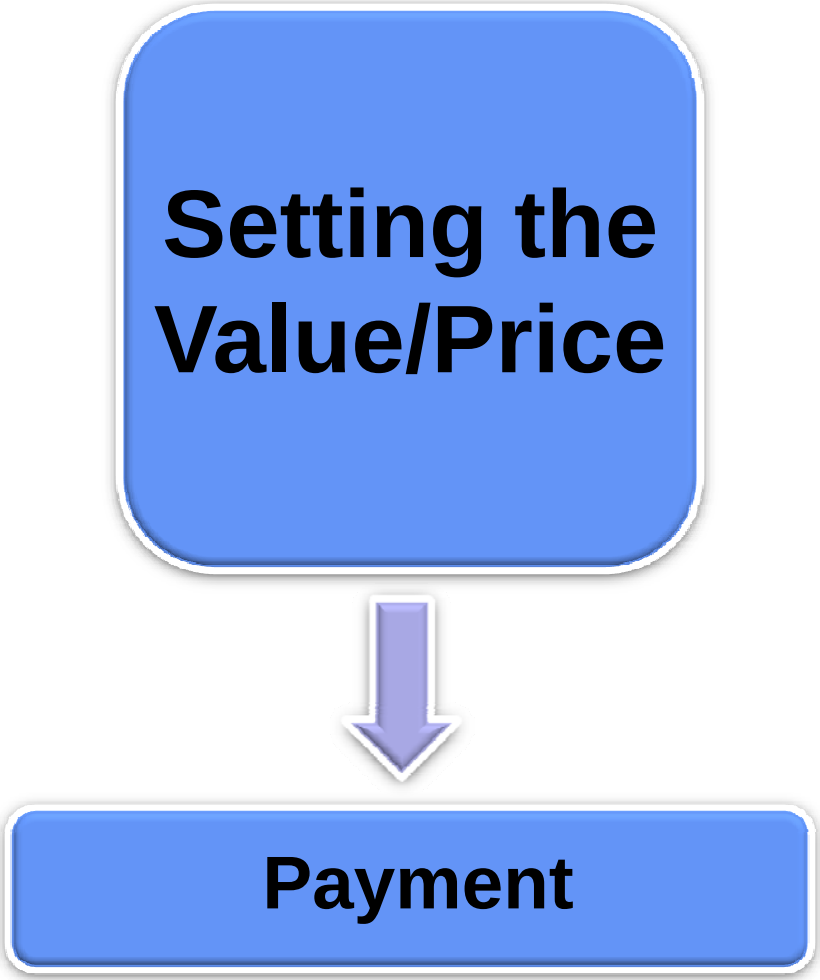

- Cost data is used to set the value (price)
  - Ontario Case Costing Initiative, Alberta costing
  - Charge data (DRG)
  - Micro-costing studies, Australia (AR-DRG)
  - Hospital financial data (UK, HRG)
- What components are in?

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- **Costing Methods:**

THE IMPACT OF USING DIFFERENT COSTING METHODS ON THE RESULTS OF AN ECONOMIC EVALUATION OF CARDIAC CARE: MICROCOSTING VS GROSS-COSTING APPROACHES

FIONA M. CLEMENT (NEE SHRIVE)[a,c], WILLIAM A. GHALI[a,b,c], CAM DONALDSON[d] and BRADEN J. MANNS[a,b,c,*]

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SUMMARY
e conduct of economic evaluations provide little guidance regarding the use

Health Policy 56 (2001) 149–163
www.elsevier.com/locate/healthpol

ORIGINAL PAPER

Comparing methodologies for the cost estimation of hospital services

S. S. Tan · F. F. H. Rutten · B. M. van Ineveld · W. K. Redekop · L. Hakkaart-van Roijen

Received: 25 October 2007 / Accepted: 20 February 2008 / Published online: 14 March 2008

Abstract The aim of the study was to determine whether the total cost estimate of a hospital service remains reliable when the cost components of bottom-up microcosting were replaced by the cost components of top-down microcosting or gross costing. Total cost estimates were determined in representative general hospitals in the Netherlands for appendectomy, normal delivery, stroke and acute myocardial infarction for 2005. It was concluded that restricting

Introduction

Economic evaluations are increasingly use
making of registration, reimbursement
hospital services [1]. The decision making
by the wide cost variations that are ob
economic evaluations that consider the sa
vice. These variations are not a problem

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nputerised patient-level costing data
ing DRG weights: the Victorian
ustralia) cost weight studies

Terri Jackson

Health Economics Unit, Hospital Services Research Group, P.O. Box 477, W. Heidelberg VIC 3081, Australia

Received 8 April 2000; accepted 16 November 2000

Abstract

Casemix-funding systems for hospital inpatient care require a set of resource weights which will not inadvertently distort patterns of patient care. Few health systems have very good sources of cost information, and specific studies to derive empirical cost relativities are themselves costly. This paper reports a 5 year program of research into the use of data from

Strategic Initiatives

- **What happens when the price is not right?**

Expanded Use Of Imaging Technology And The Cl Of Measuring Value

The benefits of expanded imaging might not be dire patients' disease outcomes.

by Lauren

ABSTRACT: ing (MRI) sca document th tentially imp dressed if va be valuable though evide thus, a parti be quantifie

When The Price Isn't Right: How Inadvertent Payment Incentives Drive Medical Care

If payment rates are not made more accurate, another powerful driver of health cost trends could be created.

by Paul B. Ginsburg and Joy M. Grossman

ABSTRACT: Unintended overpayment of some services, in combination with other market factors, is driving increased use of expensive care, which in turn could be an important driver of health care cost trends. Reimbursement systems are highly dependent on provider charge data that rarely provide accurate and up-to-date indicators of relative costs. As a result, newer services, in which productivity is increasing over time, tend to be more lucrative. As the largest payer, and one whose reimbursement policies are followed by private insurers and Medicaid programs, Medicare can address this issue by taking steps to make its prospective payment rates reflect relative costs more accurately.

Getting The Price Right: Medicare Payment Rates For Cardiovascular Services

're's prices is necessary to ensuring and disabled.

and Jeffrey Stensland

ardiac hospitals have grown rapidly. Physicians e cardiovascular diagnostic services in their of- 'rrors in Medicare's prices for hospital care and 'ove the accuracy of those prices. We find that

Strategic Initiatives

- **Can activity-based funding be credibly executed in Canada?**
- **Some of the key issues**
  - Data availability
    - Clinical
    - Financial
    - Patient level costing
  - Coding quality
    - Framework for non-adherence to standards
  - Increased demands for timeliness

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- **What are does the literature cite as key issues?**
  - Prepare for change within hospitals
    - Activity
    - Hospital financial performance
    - Management changes
  - Prepare for change in other sectors
  - Increase in the volume of the most profitable patients rather than those most in need
    - Will provinces know where highest ‘margin’ patients are without cost data?

Strategic Initiatives

- **Issues from the literature:**

  What are key implementation issues?

  - Determining service contracts between funder and hospitals
    - Setting desirable levels of activity
  - Spending ‘caps’ to limit growth of activity
  - Long-term commitment needed for hospitals to respond to incentives
  - Phased implementation
    - How quickly and to what level
  - Adjust payment amounts away from ‘average’
  - Quality?

Strategic Initiatives

- **What are some additional important risk factors?**
  - What are the critical success factors
    - Vision and Leadership
  - Political issues related to changing hospital capacity
  - Understanding the effects of natural geographic monopolies
  - Threshhold for applicability in less-populated provinces and regions
  - Understanding demand and supply of post-hospital services

Strategic Initiatives

- **ABF: What don't we know….**
  - Improve evidence-based care
  - Improve effectiveness
  - Improve safe, coordinated care between sectors
  - Impact on hospital health human resources

- **Survey: What are provinces describing as barriers to changing funding policies?**
  - High quality and accessible data
  - Expertise to guide implementation
  - Stakeholder resistance or support

Strategic Initiatives

- **Survey: Where are provinces seeking information on ABF?**
  - External experts/consultants
  - Universities, literature review
  - CIHI
- **Survey: How are provinces building capacity for ABF?**
  - Attend workshops and conferences
  - Participate in provincial initiatives and working groups
  - Internally-generated

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- **Survey: What expertise is lacking to execute ABF?**
  - Intestinal fortitude
  - Education of funding policy's affect on:
    - Overall spending
    - Quality
    - Case mix
  - Cross-training between finance and clinical areas
  - Training opportunities

Strategic Initiatives

- **'Lessons Learned' from international collaborators?**
  - One tool in the toolkit
  - ABF is a framework which needs continuous attention
  - Remove some components
    - Capital, teaching, rural, EDs
  - Setting the payment amount is really hard to balance incentives
    - 'best practice price', 'fair and achievable' or average
    - MH, geriatric, palliative, rehabilitation
  - Funding for growth in cost and volume
  - Watch for changes in settings of care, Episode splitting

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- **Hospital payment mechanisms: An overview and options for Canada (CHSRF)**
  - Some consensus on fixed/ABF hospital funding
  - Cap hospital spending when using ABF
  - Payments shouldn't be 'average'
  - Long term commitment
  - Phased implementation
  - CMG+ is cost-based reimbursement

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- **What else is present in the environment?**
  - Pay-for-Performance
  - Medical Home, Accountable Care Organizations
  - Bundling care into ‘Episodes’
    - Breaking the silos
    - Opportunities for outcome quality measures
    - Engaging physicians – transforms incentives
      - ‘gain-sharing’ accompanies risk sharing
  - Widespread discussion of incorporating quality measures into hospital/episode funding

Strategic Initiatives

- **I am in Victoria MoHS every 2 weeks (7th floor)**

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